

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TN5405	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 05/13/2015
NAME OF PROVIDER OR SUPPLIER ETOWAH HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 409 GRADY ROAD, PO BOX 957 ETOWAH, TN 37331		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
N 000	Initial Comments An annual Licensure survey and investigation of complaints #35947 and #35932 were conducted from 5/11/15 through 5/13/15, at Etowah Health Care Center. No deficiencies were cited in relation to the complaints or the survey under Chapter 1200-8-6, Standards for Nursing Homes.	N 000			

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

STATE FORM

6899

H63911

If continuation sheet 1 of 1